TCTAP C-015

An Occlusive Coronary Hematoma 5 Days After Balloon Angioplasty

Yukiyo Sakata, Kenji Sadamatsu
Saga Prefecture Medical Center Kosekan, Japan

[Clinical Information]
Patient initials or identifier number:
K.S.
Relevant clinical history and physical exam:
A 63 year-old man with worsening angina pectoris was transferred to our hospital because of severe chest pain unrelieved by nitroglycerin. His coronary risk factors were hypertension, smoking, and family history.
Relevant test results prior to catheterization:
His electrocardiogram and echocardiogram were normal, and cardiac enzymes were not elevated.
Relevant catheterization findings:
Emergency coronary angiograms revealed severely stenotic lesions in proximal and mid portions of the right coronary artery.
[Interventional Management]
Procedural step:
A 6Fr JR4 guiding catheter was engaged at the ostium of the right coronary artery and a floppy guide wire was inserted. We dilated both the lesions with a 3.0x10mm scoring balloon (Scoreflex), and deployed a 3.5x19mm bare metal stent (Coroflex) in the proximal lesion.
Case Summary:
Relevant clinical history and physical exam
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Relevant test result prior to catheterization
His electrocardiogram and echocardiogram were normal, and cardiac enzymes were not elevated.
First catheterization findings and treatment
Emergency coronary angiograms revealed severely stenotic lesions in proximal and mid portions of the right coronary artery. A 6Fr JR4 guiding catheter was engaged at the ostium of the right coronary artery and a floppy guide wire was inserted. We dilated both the lesions with a 3.0x10mm scoring balloon (Scoreflex), and deployed a 3.5x19mm bare metal stent (Coroflex) in the proximal lesion. Intravascular ultrasound findings showed a good result in the proximal lesion and only a minor dissection in the mid lesion.
Second catheterization findings and treatment
He had severe chest pain again 5 days after the treatment, and the electrocardiogram demonstrated ST-segment elevation in the inferior leads. Emergency coronary angiography revealed a sub-total occlusion in the mid portion of the right coronary artery, where the minor dissection had located in. Intravascular ultrasound findings demonstrated a occlusive hematoma, and then we covered the hematoma with a 3.4x19mm bare metal stent (Coroflex). The final angiogram showed a good result.

TCTAP C-016

Hanging Left Main Stent in Aorta in a Case of Acute STEMI with Shock with Left Main Thrombus

Anurag Sharma
Max Hospitals, Mohali, India

[Clinical Information]
Patient initials or identifier number:
Laxman singh
Relevant clinical history and physical exam:
83 Y
[Interventional Management]
Procedural step:
PCI Details:
Right femoral approach
IABP from left femoral approach
Judkins Left 3.5 guiding catheter
Rinato coronary wire
Thrombuster thrombus aspiration device 6F
3.0 X 28 XIENCE V stent
Overlapped by 2.74 X 26 supraflex stent
Instent dilatation with 3.5 X 8 MM balloon at 20 ATM.
Case Summary:
83 years old gentleman, presented to our emergency room with sweating, chest pain and giddiness while going for the evening walk.
He is non smoker, non hypertensive and non diabetic.
His BP WAS 80 mm Systolic,
Chest examination showed bilateral crepitations and room air saturation was 92%.
ECG showed ST elevation in anterior leads including I, AVL, AVR and ST depression in II, III and AVF.
2d Echo doppler showed severe LV systolic dysfunction and severe MR.
He was taken up for immediate PCI.
IABP was inserted and pt put on the high flow oxygen and PCI was done to left main and LAD.
Patient recovered well and then discharged on day 4.

TCTAP C-017

Successful Treatment of Prolonged Out-of-hospital Cardiac Arrest with Automatic Mechanical Chest Compression Device and Intra-arrest Primary Percutaneous Coronary Intervention

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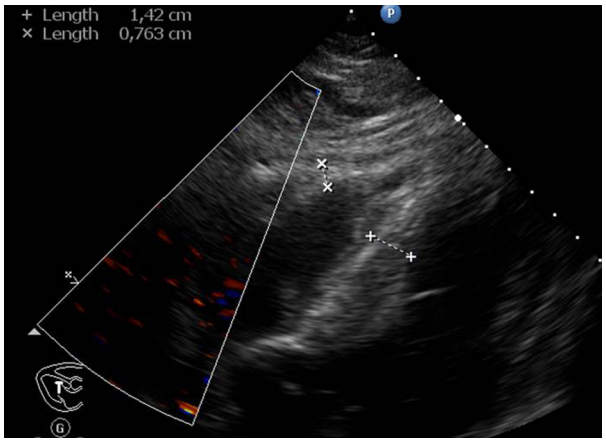
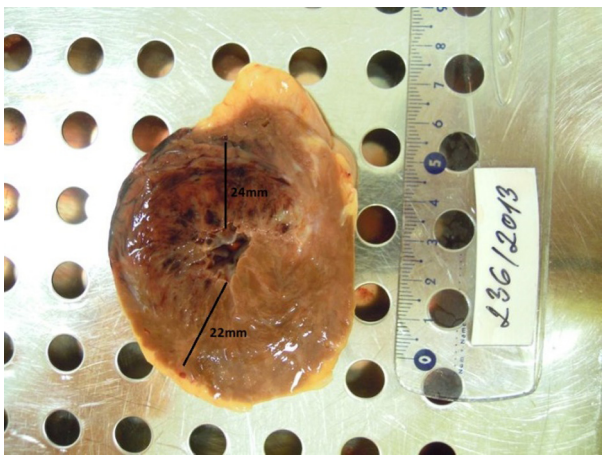
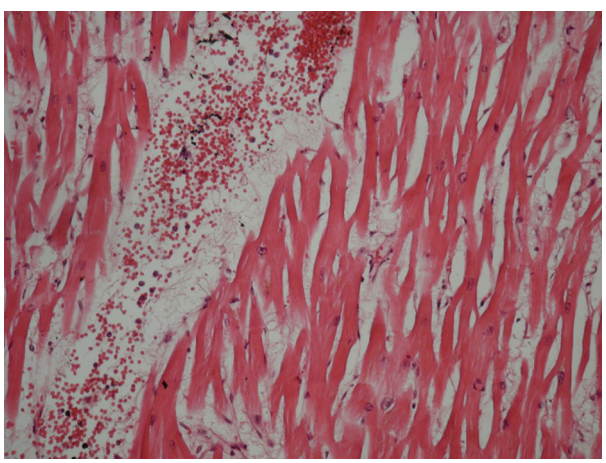
Motol University Hospital, Czech Republic

[Clinical Information]
Patient initials or identifier number:
P.G., J.S.
[Interventional Management]

Procedural step::
Cardiopulmonary resuscitation, defibrillation, use of mechanical chest compression device LUCAS2 (Medtronic, Minneapolis, MN, USA), intra-arrest pecrutaneous coronary intervention facilitated with LUCAS2. Case1: Coronary angiography revealed proximal occlusion of LAD. The closure of LAD was crossed by guidewire PT MS (Boston Scientific, USA). The artery was opened with Sapphire II PTCA Balloon 3x15mm (OrbusNeich Medical, China.) Finally, CoCr stent Skylor 4/25mm (Invatec, Italy) was deployed with final TIMI 3 flow. Case2: Occlusion of LMCA was crossed by guidewire PT MS (Boston Scientific, USA). The artery was opened with Sapphire II PTCA Balloon 3x15mm (OrbusNeich Medical, China). Another guidewire PT MS was advanced. Finally, CoCr stent Skylor 4/20mm (Invatec, Italy) was deployed.







Case Summary:
We present a series of two case reports of patients (48- and 60-year-old man without previous history of coronary artery disease) with acute ST-elevation myocardial infarction complicated by out-of-hospital cardiac arrest unresponsive to advanced cardiopulmonary resuscitation. Both patients were treated with use of an automated mechanical compression-decompression device LUCAS 2 (Medtronic, Minneapolis, MN, USA). Coronary angiography showed occluded proximal left anterior descending artery in the first case and total occlusion of the left main coronary artery in the second case. In both patients a successful intra-arrest primary percutaneous coronary intervention (PCI) was performed. LUCAS could be discontinued immediately after the reperfusion. Return of spontaneous circulation (ROSC) was achieved in both cases after 90 minutes of cardiac arrest. The first patient survived to hospital discharge without any neurological impairment, control coronary angiography showed good result of PCI. On a 1-year follow-up visit he was in a good condition, echocardiographic examination showed mild spherical remodeling of LV with EF 0.35. The second patient died of cardiogenic shock 11 hours after onset of symptoms. An echocardiogram performed after ROSC showed increased echogenity of both right ventricle and interventricular septum (IVS) and "hypertrophy" of right ventricle (8mm), IVS (14mm) and lateral wall of left ventricle suggesting cardiac contusion. An autopsy revealed a transmural anterolateral myocardial infarction but also massive subepicardial hemorrhage, extreme LV "hypertrophy" with IVS and lateral wall thickness of 24mm and 22mm respectively and interstitial edema and hemorrhages on histologic samples from regions of the myocardium outside the infarction itself and also from the right ventricle. These lesions were concluded to be a myocardial contusion.

TCTAP C-018

Simple Transradial Intervention Becomes Complex

Mir Jamal Uddin
National Institute of Cardiovascular Diseases, Bangladesh

[Clinical Information]
Patient initials or identifier number:
AS
Relevant clinical history and physical exam:
A young man of 38 years presented with gradual onset of exertional chest discomfort NYHA stage |||. He was known diabetic and hypertensive. On examination o/e pulse 70/min.blood pressure 150/100 mmhg.Heart and lungs revealed no abnormality other systemic examinations revealed normal
Relevant test results prior to catheterization:
ECG showed inferior ischemia. Echo Revealed regional wall motion abnormality.ETT was positive.Other biochemical tests remained normal
Relevant catheterization findings:
transradial CAG done which revealed LM-normal LAD -normal LCX-normal RCA-mid 70-80% % lesion
[Interventional Management]
Procedural step:
TRI planned radial guide catheter (tiger) 6F was engaged to the RCA ostium. Guide catheter hits the proximal RCA twice. And there occurred a dissection. A BMW wire was crossed the lesion. The lession was pre dilated with 1.5 × 20 mm balloon. There was another dissection occured in the mid part of RCA.i decided to stand it with a long DES 2.75x28 mm. After deploying the stand at the mid part of RCA, good TIMI ||| flow achieved. Then proximal dissection flap was covered by another DES 3.0x28 mm at 16 atm. After placing the secondstand I noticed there was haziness at the distal end of first stand with distal slow flow.I thought it was another dissection by the stand. So I deployed another DES at the distal RCA which was 2.75x16 mm over lapping the first stand. Final result was good with TIMI ||| flow